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ABSTRACT

The proceedings of a 3 day institute on early intervention programs for emotionally handicapped preschool children include two brief presentations on parent relations and toilet training of children with developmental problems. Described is an individualized approach to working with parents which focuses on helping mothers to acquire attitudes and techniques for fostering their child's learning and development through parent group support and through discussions of topics such as discipline, basic routines of sleeping and eating, and the etiology and treatment of childhood schizophrenia and autism. Stressed is the need for professionals to help the mother deal with her anxieties and develop realistic expectations for her child rather than blaming her for the child's pathology. Toilet training is viewed as a complex process of learned behavior which can be taught through clear directions, special procedures (such as getting the child's attention and regularly scheduled intervals), and positive reinforcement techniques. Step-by-step guidelines are presented for preparing and initiating the toilet training program. (LH)

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"DEVELOPING EARLY INTERVENTION PROGRAMS FOR EMOTIONALLY HANDICAPPED CHILDREN"

April 1, 2, 3, 1974

Colonie Hill
1717 Motor Parkway
Hauppauge, New York

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Reprint: **PRE-SCHOOLER'S WORKSHOP**
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"Parent Relations"

Judith Bloch, Executive Director, Pre-Schooler's Workshop, addressed the group as follows:

"Parents of disturbed children have been subjected to a variety of judgements, criticisms, and therapies in the last twenty-five years by the professional community. For a long time all parents of psychotic and autistic children were thought to be disturbed and in need of psychotherapy. Today the panacea is behavior modification, and some clinicians suggest all parents should be trained as co-educators.

At Pre-Schooler's Workshop in Garden City there is an individualized approach in working with the parents of children, just as there is an individualized prescriptive teaching method for the children, all of whom have serious problems with learning, language or behavior. The parents of the children are presumed to be neither the culprit, and responsible for producing the pathology of their child, nor necessarily a potential co-therapist. Since each family situation differs, and each parent has different strengths and problems, a number of alternatives are made available.

All the parents participate with the director, and clinical and teaching staff, in arriving at an assessment of their own child's current functioning. At the same time a determination is made about the manner in which the parent will participate in the education and therapy of their own child. Pre-Schooler's Workshop offers traditional child focused counseling services provided by the social worker; and consultation by the school psychiatrist. There are different kinds of mothers' groups. One is subject and content focused and coordinated by the social worker with the teacher and language therapist. The more classically oriented 'group therapy' program is generally focused on parental reactions and feelings rather than technique although there is considerable overlap. A home study program and 'mothers as classroom aides' are additional modalities for working with parents.

Mothers' groups are subject focused and child centered. Mothers are not assumed to be responsible for their child's pathology. When parents do have personal problems, it is not automatically understood that this has a direct bearing on the functioning of their children or that this problem has in fact

resulted in their child's condition.

On the other hand, all children are affected by their environments. Disturbed children are even more fragile and vulnerable because they have fewer resources and defenses. Therefore, their parents carry a greater burden. They must be 'supermothers' who are more perceptive, more sensitive, and make fewer mistakes in child rearing than do parents of children without special problems. The parents, particularly mothers who are usually responsible for the day to day activities of their children, need to become familiar with the attitudes and skills that will help their children most fully develop their own potential. If all parents benefit from further clarification of these concepts then certainly the parents of the handicapped benefit even more significantly. One can assume that a handicapped child is more likely, because of his handicap, to be more vulnerable. The child, labeled mentally ill, psychotic, or seriously disturbed, needs as much special assistance as early in his life and for as extended a period of time as he is capable of utilizing. His own parents, his most natural allies and most motivated advocates, should be mobilized and enlisted in his struggle for health.

In the subject focused group, the professional leader is responsible for current informed content and guidelines about problems that characterize the child with pathology at various steps in his development. Typically a session (of one and a half to two hours with approximately ten mothers present) begins with a half presentation by the leader. The subsequent course of the meeting is respondent to the groups interest and inclination. In this kind of group the professional group leader does not confront or challenge parent participants with their anger or disappointment, although parents are given ample opportunity to express these feelings if they choose to do so. All parents experience these feelings towards their children at some time. We assume that this is equally true of the parent of the disturbed child. In all likelihood this parent's feelings are even more intense, because the problems and provocations are more difficult. Anxious, frightened parents are only further disabled by questions and professional attitudes that make them more guilty and uncertain.

Parents of handicapped children need each other for the support and the special wisdom and understanding that develops from a common experience. Frequently a mother who has experienced and resolved a typical and difficult problem is most helpful to

other mothers still struggling with that same problem. Parents learn there are attitudes as well as techniques that hasten learning and development. Some of the topics of great concern over the years have been:

1. Etiology of childhood schizophrenia and infantile autism; and the various schools of thought in dealing with this pathology. A bibliography is recommended along with information about parent groups such as the National Society for Autistic Children and the Association for Children with Learning Disabilities, etc.

2. Dealing with basic routines of sleeping and eating before the child is five years old

3. Toilet training; when and now

4. Discipline; dealing with temper tantrums and aggression

5. Fostering language in school and at home

6. Becoming part of a family; the rights of parents and siblings

The topic for discussion is flexible. One subject may extend itself to a number of sessions. If food and diet is presenting some parents with special problems, that sub-group of parents meets again for additional sessions and a workshop with the leader during which the group may be joined by the teacher who tells of her classroom orientation to this problem. The parent group might also observe a class during juice or lunchtime.

Teachers write three anecdotical reports a year, and complete an assessment form in September and again in June. Copies of these reports as well as reports from the speech pathologist are mailed to the parents, and are the basis of conferences with teachers and clinicians. A written report is deliberately shared in order to give the parent an opportunity to study it carefully at his leisure, and keep it as a permanent objective record of assessment and functioning. The more typical verbal report (rendered by a school) was found to be inadequate; the parent often too anxious to hear, much less integrate and apply school recommendations. Since these reports state goals and objectives along with a description of the child's current functioning, they also serve as a guideline for realistic parental expectation.

Professionals have underestimated the capacity and willingness of parents to acquire the skills and attitudes that will help their children learn. At our school, the parents of several autistic children have cooperated with the professional staff and developed and designed an individualized program for their child; implemented in the classroom and again at home. This procedure compels parents and staff to clearly assess current functioning; focus on the behavior to be acquired, arrive at agreement about priorities, and design techniques and procedures for realizing behavioral objectives. Parents keep record of their child's progress, reevaluate and re-program periodically in cooperation with the staff. When necessary a staff person serves as a model that the parent observes. With this procedure it is more likely that the child's newly acquired skills are generalized and transferred from home to school (or the reverse). Participating parents have the satisfaction of successfully engaging in the education of their child.

In the eight years of experience at Pre-Schooler's Workshop our staff has found that parental reactions at the point of application and screening, and in the initial phase when the child begins in the program, seem most intense and exaggerated. It is important if ongoing viable relationships are to be established between parents and staff that the professional staff be available at this point of high anxiety and not later in the school year when it may be more convenient for the professional. Over the years, Pre-Schooler's Workshop's staff has also noted that a very large percentage of parents of the school children seem to have a difficult first year of adjusting, during which time a diagnostic evaluation on the child has been completed and he has entered a special school. This initial year seems to be one of mourning and grief as parents come to a greater realization that their child's difficulties may be long-lasting, all the pathology may not be reversible, or that there are limitations to the child's potential capacity to learn and function. For some parents the mourning is for the death of their dreams and expectations for their child, whose special problems abruptly compels them to deal with his limitations so that they must give up some of the fantasies and hopes many parents have for their children.

The literature describes perplexed and anxious mothers. While we too have seen uncertainty and confusion in many mothers, it seems a reactive (rather than causative) pattern to unpredictable, chaotic behavior on the part of their children. Professional

women in the field should draw on their own personal mothering experiences, and not rely so heavily on the professional literature which is still dominated with male oriented judgement and expectations of mothers. In my own personal and professional experience, it has not been unusual to see parents of children without pathology respond to rage in children with rage, anxiety with anxiety, and other strong emotional reactions with similarly intense feelings. Because most children can cope with strong parental reaction without deviance or pathology, those parents can assuage their subsequent guilt at their own imperfect parental reaction. Unfortunately, the daily confrontation with the special management problems of disturbed children compels these parents to become preoccupied with their coping skills and attitudes. Their angry, and sometimes guilty thoughts and feelings, should not be further aggravated (rather than reduced) by the professional community's judgmental response.

As in so many life situations, learning to perceive and respond in a manner that enhances and nurtures the growth of these deviant children is a different, long term process. The professional must allow this process of initial parental reaction and subsequent relearning and acquiring of new, more satisfying skills and attitudes the time it requires."

PRE-SCHOOLER'S WORKSHOP
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Prepared by: Judith Bloch, ACSW

TOILET TRAINING OF CHILDREN WITH DEVELOPMENTAL PROBLEMS

Introductory Comments:

Children with language, learning, or behavior disorders usually present difficulties in becoming toilet trained. It is important to remember that the achievement of toileting is a complex process of learned behavior. For children with problems of language, perception, body image, delayed development, or other handicapping conditions, the adult's communication, gestural or verbal, must be as clear and simple as possible. Our children are usually more fearful and more negative, and their toilet training takes longer to accomplish. But, even autistic children who are highly resistant and seem unaware of themselves can be trained before they emerge from their autistic unrelatedness and by the time they are no older than five years of age.

Teaching new behavior should be broken down into small step-by-step segments. Clear directions, special procedures, and reinforcement techniques which serve as a reward of learning will hasten the acquisition of more appropriate behavior patterns.

While each child has to be dealt with on an individual basis, the following guidelines will be helpful to parents who are struggling with this problem.

Preparation for a toilet training program:

1) The child must be ready for training, which means he or she remains dry for at least two consecutive hours.

2) The parents must be ready to undertake the task and should have a three week period in which training can be initiated and continued in a consistent way, even through the weekends. They begin by keeping a daily log for seven days, recording the time and frequency of urination and bowel movements. Make notations of whether the child is upset (under what circumstances) aware he has soiled, or notices the puddles he makes.

3) The toileting place should be specific and predictable so that the child is aware of what is expected when he is taken there. In short, the toileting should be done in the bathroom in one regular place, either the toilet or a special potty.

4) Training pants should replace diapers so that a child becomes more aware of his functioning and can cue in better to his own body signals. It has been found helpful in training to substitute training pants for diapers even at night, but it entails more work for parents at beginning.

PRE-SCHOOLER'S WORKSHOP

TOILET TRAINING OF CHILDREN WITH DEVELOPMENTAL PROBLEMS

Initiating the toilet training program:

1) Some children may first have to be helped overcome a fear of the toileting place. Pleasant play activities in the bathroom, without any toileting demands, may be necessary as the initial step.

2) Some children have to be helped to learn to sit on the toilet for more than a few seconds. Where this is a problem, a program can be set up to extend a child's ability to sit, through appropriate reinforcements - (looking at himself in the mirror, looking at a book, etc..) Once the ability to sit for 5-10 minutes is achieved, the reward for this can be slowly withdrawn.

3) The adult who initiates the program should not autimatically flush the toilet if there is any evidence the child is frightened by this. That phase of toileting should then be postponed.

4) The child is brought to the bathroom on the appointed schedule; at regular intervals, usually after each meal, before he goes to bed, and when he has been dry for over an hour. The adult calmly takes the child to the bathroom. Say "_____", let's go to the toilet." Get the child's attention, make eye contact. Show him the special food or toy reinforcer that you have previously determined he likes and tell him he will get this when he performs. He is quietly told to take down his pants and underpants. Help is given, if needed. If he can do any of this, he is shown approval with a smile, a pat, or verbal praise - sometimes all three.

5) The child is praised and encouraged to perform, urinate or defecate (use the same words each time) in as calm and relaxed a climate as can be mustered. If a child does not perform after a maximum of ten minutes or if he starts to become restless or distressed, he dresses or is helped to dress and goes with the adult <u>without comment</u> to his next activity. If, however, he performs <u>appropriately</u>, he is immediately rewarded verbally and with food, if this is a reinforcement for him.

6) Toilet training may not progress evenly; it usually takes longer to achieve with our children; be patient. If there are special problems, reassess procedures with staff.

7) It is suggested that performance charts, kept both at home and at school, will help in evaluating and coordinating the program.